MDR Tracking Number: M5-04-0949-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on December 1, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the electric stimulation, vasopneumatic devices, chiropractic manual spinal treatment, office visits with manipulation and neuromuscular re-education were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 01-21-03 to 09-29-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Amended Letter
Note: Decision

February 25, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0949-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury on ___ while lifting heavy boxes and felt a pop and burning in his lower back. He then reported numbness in the toes also. He underwent a designated doctor examination (DDE) on 05/11/01, was placed at maximum medical improvement (MMI) on that date, and given a 19% impairment rating.

Requested Service(s)
Electrical stimulation, vasopneumatic devices, chiropractic manual spinal treatment, office visits with manipulation, and neuromuscular re-education from 01/21/03 through 09/29/03

Decision
It is determined that the electrical stimulation, vasopneumatic devices, chiropractic manual spinal treatment, office visits with manipulation, and neuromuscular re-education from 01/21/03 through 09/29/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The rationalization of the provider to continue with the utilization of passive therapeutics to treat this patient's medical condition is not clear from the reviewed medical records. It is evident that the provider treated this injured worker from 09/20/99 through 05/11/01 with chiropractic applications and was unsuccessful in returning the patient to work and function. It is not clear how the application of additional passive therapeutics that include spinal manipulative therapy and passive modalities "cures or relieves" this patient's condition in any way. There is a temporal benefit, but it is clear that this patient's condition has progressed beyond the necessity of temporal relief.

Utilization of passive modalities and spinal manipulative therapy are not active, patient-driven applications. The patient will not show any measurable amount of improvement from the continued utilization of these therapies. Therefore, it is determined that the electrical stimulation, vasopneumatic devices, chiropractic manual spinal treatment, office visits with manipulation, and neuromuscular re-education from 01/21/03 through 09/29/03 were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- Kankaanpaa M, Taimela S, Airaksinen O. *The efficacy of active rehabilitation in chronic low back pain. Effect on pain intensity, self-experienced disability, and lumbar fatigability.* Spine. 1999 May 15; 24(10): 1034-42.

- Niemistö MD, L, et al. *A Randomized Trial of Combined Manipulation, Stabilizing Exercises, and Physician Consultation Compared to Physician Consultation Alone for Chronic Low Back Pain.* Spine 2003; 28(19): 2185-2191.

Sincerely,